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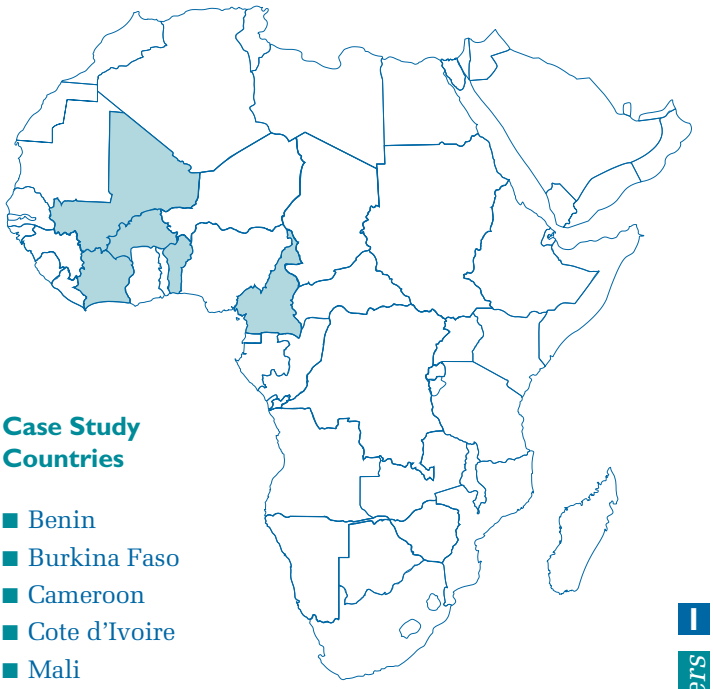
Post-Cairo Reproductive Health Policies and Programs in Five Francophone African Countries

This summary is based on the research report, "Post-Cairo Reproductive Health Policies and Programs: A Study of Five Francophone African Countries," by Justine Tantchou and Ellen Wilson. The report is based on country case studies prepared by Béatrice Aguessy, Paschal Awah, Hafsatou Diallo, Elisabeth Fourn, Zoumana Kamagate, Stanislas Paul Nebié, Idrissa Ouedraogo, Aminata Noëlle Sangaré, Tamo Tamboura, Justine Tantchou, and Mahamadou Traore. Claire Viadro prepared this brief.

Background

The International Conference on Population and Development (ICPD), held in Cairo in 1994, focused worldwide attention on reproductive health. In Francophone Africa, however, where family planning services were not introduced into national health programs until the 1980s and population policies generally were not adopted until the 1990s, reproductive health has attracted notice more slowly than in other regions of the world.

This summary reports on case studies prepared by the Network for Reproductive Health Research in Africa (RESAR)[1] in five Francophone African countries—Benin, Burkina Faso, Cameroon, Côte d'Ivoire, and Mali.[2]



Case Study Countries

- Benin
- Burkina Faso
- Cameroon
- Cote d'Ivoire
- Mali

Findings

The reproductive health policy focus in Francophone Africa has evolved during the past two decades. Initially strongly pronatalist, countries began by accepting maternal and child health (MCH) programs, then MCH programs with family planning, and, finally, reproductive health. Following the ICPD, the region refined its approach to reproductive health at the Ouagadougou Forum held in

[1] RESAR receives grants from governmental and nongovernmental organizations (NGOs) as well as bilateral and multilateral donors to improve reproductive health through research and training. RESAR is made up of 10 national units in Francophone Africa.

[2] Between October and December 1998, RESAR members interviewed 25 to 29 key informants in each country who were active in formulating and implementing reproductive health policies and plans. Informants included service providers as well as representatives of ministries, parliaments, universities, NGOs, women's groups, the private sector, donor agencies, and U.S. technical assistance organizations. Interview topics included reproductive health definitions, priorities, and policy formulation; support for and opposition to reproductive health; program implementation; financial resources; and challenges to implementing reproductive health policies and programs. Published materials and other documents were also reviewed when appropriate.

September 1996.[3] The framework adopted by forum participants has influenced development of national policies and programs.

The Policy Process

In response to the ICPD, the Ouagadougou Forum, and other regional workshops, the five Francophone countries have worked to revise policies, standards, and procedures to incorporate a reproductive health perspective. All five countries have adopted the ICPD definition of reproductive health. In 1998, Côte d'Ivoire approved a comprehensive reproductive health policy. At the time of the case studies, Benin and Mali had drafted policies that were still awaiting final approval, and Burkina Faso and Cameroon had not finished drafting policies. Each country can point to a variety of policy accomplishments:

- **Benin's** 1995–1999 health strategy included improved reproductive health as one of five areas of intervention. In 1996, Benin adopted a population policy and, in 1997, defined an essential services package for reproductive health. A subsequent strategic framework for development of the health sector (1997–2001) makes the Directorate of Family Health responsible for creating and monitoring reproductive health programs. A reproductive health policy was adopted in early 1999.

- After the ICPD, **Burkina Faso's** population policy, first adopted in 1991, was updated to include reproductive health as a national priority. The new emphasis on reproductive health shifted focus from controlling population growth to improving quality of life, and the Ministry of Health has begun developing a reproductive health strategy. At present, there is not a single coordinating unit or committee responsible for reproductive health.

- Policymakers in **Cameroon** have worked to revise the country's 1992 population policy. Moreover, in 1996, family planning was integrated with MCH, contraceptives were included on the list of essential drugs, and a national health policy specified an essential services package that includes reproductive health. Because of the reclassification of the former Directorate of Family and Mental Health as a subdirectorate, the country lacks an effective coordinating structure for reproductive health policies.

- In 1996, **Côte d'Ivoire** adopted its first health development plan (1996–2005), encompassing several reproductive health programs, followed by a population policy in 1997. In 1998, the country approved policy documents, standards, procedures, and programs for reproductive health and passed laws against female genital mutilation and early, forced marriage. The National Program for Reproductive Health and Family Planning is responsible for policy development within the Ministry of Health, but no institution has a clear mandate to coordinate reproductive health policies.

- **Mali** has strengthened and expanded its 1990 population and health policy. In addition, the country's MCH policies and standards have been replaced with policies, standards, and procedures for reproductive health and fam-

[3] The First Regional Forum on Reproductive Health for Central and West Africa was initiated and organized by the Family Health and AIDS Prevention (SFPS) Project and funded by various international donors.

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ily planning. Reproductive health is the first component of the 1996–2000 population policy action plan. A 1998–2002 program for health and social development proposes the creation of a reproductive health directorate.

None of the five countries has set explicit reproductive health priorities. However, programs tend to emphasize MCH, birth spacing, and STD/AIDS prevention, placing less emphasis on family planning for purposes of birth limitation, infertility, reproductive tract cancers, and reproductive rights. Other areas of emphasis have included gender issues, quality of care, and the social context for health, resulting in more services for youth and men and programs addressing female genital mutilation.

Participation, Support, and Opposition

Respondents in all five countries confirmed that NGOs and other civil society representatives have been involved in national or subregional meetings to formulate reproductive health policies and programs. In Cameroon and Côte d'Ivoire, the number of NGOs actively working in reproductive health has increased since the ICPD, and NGOs in Benin and Mali have formed networks to enhance their effectiveness. In Benin and Burkina Faso, nongovernmental respondents stated that NGOs have not been allowed to function as genuine partners in planning and implementation.

Although overall support for reproductive health is increasing, many groups do not yet accept some elements, such as the elimination of female genital mutilation or the provision of family planning services to adolescents. Respondents described government officials and politicians as generally open to reproductive health concepts and strategies, particularly as leaders have developed an understanding of the consequences of rapid population growth and have accepted family planning as a central element of MCH. Respondents perceived grassroots social conservatism as a barrier to program development and noted that some Islamic and Catholic religious leaders opposed aspects of reproductive health. Benin and Mali have never repealed a little-used but symbolically significant 1920 French law forbidding abortion and publicity about contraception.

Moving from Policies to Programs

Increasingly, countries are considering reproductive health in the broader context of gender issues, most notably in Burkina Faso. Although all five countries have taken action to apply ICPD and Ouagadougou Forum resolutions, implementation of programs with a reproductive health orientation lags behind. Moreover, despite ICPD recommendations emphasizing the importance of integrating reproductive health services to increase efficiency and better meet the needs of clients, integration of services has been slow to occur.

Government clinics provide most reproductive health services, except in Côte d'Ivoire. However, NGOs are predominant in programs that address youth, women's rights, and female genital mutilation; the private and religious sectors are also active in some of the countries. Some respondents mentioned the difficulties of coordinating government and NGO activities. With support from donors, social marketing and community-based distribution initiatives have taken root in some countries. All five countries—particularly Mali—have attempted to increase community participation in the management of government health services (including reproductive health care) in accordance with the Bamako Initiative.[4]

Financial Resources

With the exception of Côte d'Ivoire, none of the countries has a specific line item for reproductive health, and government budget allocations for health programs are generally low. Two countries have made noteworthy efforts to increase their contributions. Mali allocated more than one-tenth of its 1996 national budget to health, and in Côte d'Ivoire, contributions to reproductive health increased dramatically between 1995 and 1997. The proportion of the national budget allocated to health was the lowest in Cameroon (less than 5 percent). Although respondents acknowledged the critical importance of

[4] In 1987, African ministers of health launched the Bamako Initiative to ensure the universal availability of affordable primary health care. To improve quality and foster the effective use of resources, the initiative promotes community financial contributions to health services, community participation in decision making, outreach by village health workers, an essential services package, and a decentralized, district-based health system.

donor support, upon which all five countries depend heavily, some expressed concern about overdependence and the associated threat to program continuity when donors withdraw. Countries are making efforts to improve program sustainability by implementing and reinforcing cost-recovery systems as outlined in the Bamako Initiative.

Policy Implications

All five countries have made significant progress in developing reproductive health policies, but only limited progress in implementation. Because the countries share a similar colonial heritage, exhibit the same general social and cultural patterns, and face many similar economic and development challenges, the case studies, not surprisingly, reveal numerous similarities. Moreover, the five countries interact regularly, participating in the same regional conferences, using neighbors' policies and programs as models, and consulting the same technical experts and donor representatives. Although each country is unique, the case studies point to a number of shared challenges:

- **Understanding of and Support for Reproductive Health.** Many respondents commented that the reproductive health policies promoted by the ICPD and Ouagadougou Forum require further dissemination. The concept of reproductive health is still not widely understood, particularly outside the capital cities. Some countries have taken steps to increase service providers' awareness of the new reproductive health orientation and to provide them with training so that they are competent to offer users a broad range of integrated services.

- **Coordination.** Countries have made limited progress in coordinating reproductive health and population policies and programs, in part because responsibility tends to be divided among the ministries of health, planning, and education, as well as donor agencies and NGOs. The adoption of an integrated reproductive health approach will require greater coordination among the large number of actors involved in implementing various program components.

- **Priorities.** As countries have developed reproductive health initiatives, most national programs have failed to systematically determine priorities. As a result, organizations have been left to address their own perceived priorities. Setting national priorities is critical if the region's limited resources are to be effectively channeled to the areas where there is greatest need. Moreover, countries need to address the unequal distribution of existing personnel and infrastructure in urban versus rural areas.

- **NGO Participation.** Although the number of reproductive health NGOs has multiplied in recent years, the institutional weakness of many NGOs limits their ability to participate effectively in developing and implementing reproductive health programs. In addition to working to strengthen NGOs, governments need to go beyond token NGO involvement and begin to engage NGOs as full-fledged partners.

- **Use of Resources.** Although all five countries have limited financial resources and rely heavily on donor assistance, a number of respondents noted that using resources more effectively and efficiently was as important as generating more external or internal funding.

The difficult sociocultural, economic, and political context that prevails in much of Francophone Africa continues to limit the widespread availability of reproductive health services. Much remains to be done in the area of program implementation. Because poverty and underdevelopment are major constraints, it is particularly important that countries focus their efforts on identifying and implementing priority interventions while improving the efficient use of existing resources.